COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

NOTIFICATION TO INTERESTED PARTIES REGARDING RETURN/DISCHARGE OF PATIENT ABSENT WITHOUT AUTHORIZATION

☐ Court _____
Name of Court

☐ District Attorney _____
County

☐ Next of Kin _____
Name/Address

☐ Legally Authorized Representative (i.e., Guardian) _____
Name/Address

Police: ☐Local: Town/City:_____
Contact Person

Town/City:_____
Contact Person

Town/City:_____
Contact Person

☐State: _____
Contact Person

☐Campus: _____
Contact Person

DMH Area _____ Date _____ Time of Notice _____

Facility _____ Address _____

Facility Contact Person _____ Telephone_____

Name of Patient _____ DOB_____ Legal Status_____

Sex: ☐ M ☐ F Home Address _____

Pursuant to 104 CMR 27.16 (3)(b), you are hereby notified that the just named patient who was absent without authorization from this facility as of _____ was (check one):
date

☐ returned to the facility on _____ .

☐ discharged from the facility on _____ .

Instructions: Individual copies of this form shall be sent to any or all of the above, as appropriate, and filed in the patient's medical record.

Form AWA-4